STATE OF HAWAII
TEMPORARY DISABILITY BENEFITS PLAN
for
BARGAINING UNIT EMPLOYEES

Attachments

Table A	Duration of TD Benefits for All Employees (except BU 11 employees on 56-hour workweek)
Table B	Duration of TD Benefits for BU 11 Employees on 56-hour Workweek
Form HRD (TDI)-1 Rev. 2/00	Claim for Temporary Disability Benefits
Form TDI-46, Rev. 01/00	Denial of Claim for Disability Benefits (claimant's appeal on reverse side or second page)
	Notice to Employees

Effective JUL -6 2000, this Plan amends and replaces the Temporary Benefits Plan issued on May 1, 1987.

A. PURPOSE

The purpose of this plan is to comply with the applicable requirements of Chapter 392, Hawaii Revised Statutes, and its regulations. To meet these requirements, the State of Hawaii hereby establishes a Temporary Disability Benefits Plan (hereinafter "Plan") for eligible State employees in the executive branch of government.

B. POLICY

Eligible State employees in the executive branch of the government who are unable to work because of a disability due to a non-work related injury or illness and who meet the coverage, eligibility and other requirements of the Plan and Chapter 392, Hawaii Revised Statutes, and its regulations, shall be entitled to temporary disability benefits.

The specific temporary disability benefit shall provide partial wage replacement up to a maximum duration of 26 weeks per benefit year after:

(1) serving a mandatory seven calendar day waiting period starting from the first day of each disability and

(2) using all accumulated (unused) sick leave credits before the benefit is allowed.

The amount of temporary disability benefit shall be based on:

(1) 58% of the employee's average weekly wage or

(2) the "maximum weekly benefit amount" as annually established by the Disability Compensation Division of the State Department of Labor and Industrial Relations,

whichever is less.

C. Coverage

All State employees who are in the executive branch of the government and are included in collective bargaining units 1, 2, 3, 4, 9, 10, 11, and 13, pursuant to Chapter 89, Hawaii Revised Statutes, shall be covered by this Plan.

Inclusion: This plan shall also cover emergency hires in the executive branch who are not included in any of the collective bargaining units described above.

Exception: Employees who have the same sick leave allowance as school teachers in the Department of Education shall be excluded from coverage under this Plan and shall be covered under the Department of Education School Code Regulation #5405, TEMPORARY DISABILITY INSURANCE (EXTRA SICK LEAVE). Such employees shall include, but not be limited to the following:

1. School Food Service Managers
2. Educational Assistants
3. School Security Attendants
4. School Health Aids
5. Social Workers*
6. Psychological Examiners*
7. Educational Evaluators*
8. Speech Pathologists*
9. School Psychologists*

*Effective 7/1/87

D. DEFINITION OF DISABILITY

"Disability" means total inability of an employee to perform the duties of his/her employment caused by sickness, pregnancy, termination of pregnancy, or accident other than a work injury. (A work injury covered by Section 386-3 or 79-15, Hawaii Revised Statutes, shall not be considered as a disability for purposes of this Plan.) Consecutive periods of disability due to the same or related cause and not separated by an interval of more than two weeks shall be considered as a single period of disability.

E. SICK LEAVE PROVISIONS CONTAINED IN COLLECTIVE BARGAINING AGREEMENTS

The requirements and conditions contained in this Plan shall not modify or amend any sick leave provisions contained in the respective collective bargaining agreements. However, the Plan, as approved by the State Department of Labor and Industrial Relations, requires that a covered employee who claims entitlement to benefits under the Plan be required to exhaust his/her accumulated (unused) sick leave credits before temporary disability benefits are allowed.

F. ELIGIBILITY REQUIREMENTS

To be eligible for benefits, an employee must have during any part of the fifty-two (52) weeks immediately prior to the first day of disability occurring after December 31, 1999:

(1) worked for any covered employer in the State of Hawaii for at least fourteen (14) calendar weeks (need not be consecutive);

(2) received remuneration in any form for twenty (20) or more hours during each of the fourteen (14) weeks; and

(3) earned at least $400.

Before benefits are granted, an eligible employee must meet all of the following conditions:

(1) The employee's injury or illness is not work related (not caused by the job).

(2) The injury or illness prevents the employee from performing his/her regular work.

(3) The employee's disability is certified by a licensed physician, surgeon, dentist, chiropractor, osteopath, naturopath, or an accredited practitioner of a faith-healing group.

(4) The employee is employed as a covered State employee immediately prior to the date of disability or, if the employee is separated from covered State employment, the disability occurred within two weeks from the date of separation and the separated employee did not enter into new employment with an employer subject to the Hawaii Temporary Disability Insurance Law.

(5) The employee has used or will use all of his/her accumulated (unused) sick leave credits before receiving benefits.

G. DISQUALIFICATION PROVISIONS

A covered employee shall be disqualified from receiving temporary disability benefits if any one of the following applies:

(1) The employee's Sick Leave Computation provides sick leave coverage for a total of three weeks or more at the beginning of the calendar year or at the time of disability. (See Section K to calculate an employee's Sick Leave Computation.)

(2) The employee received temporary disability benefits for the maximum duration allowed in a benefit year based on Section K and the applicable table of this Plan.

(3) The employee performed work for remuneration or profit during the disability.

(4) The employee was denied unemployment insurance benefits under the Hawaii Employment Security Law because of a work stoppage due to a labor dispute.

(5) The employee's injury was self-inflicted willfully and intentionally or it was received while committing a criminal offense.

(6) The employee received or will receive unemployment insurance, workers' compensation, federal disability benefits, or "Act 64" benefits under Section 79-15, HRS, for a work related disability.

(7) The employee knowingly makes a false statement, misrepresents a fact or fails to disclose a material fact in order to obtain benefits.

(8) The employee fails to meet any other condition or requirement contained in this Plan.

H. WAITING PERIOD

An eligible employee shall be required to serve a mandatory waiting period of seven (7) consecutive calendar days starting from the first day of each disability and no temporary disability benefits shall be payable during such waiting period. It is provided that consecutive periods of disability due to the same or related cause and not separated by an interval of more than two weeks shall be considered as a single period of disability.

During the seven (7) calendar day waiting period, the following shall be applicable:

(1) All accumulated (unused) sick leave credits, as available, shall be applied to the employee's working days of the waiting period. (It should be noted that the requirement to use all accumulated sick leave credits before temporary disability benefits are allowed is in addition to the waiting period requirement. Consequently, the mandatory usage of accumulated sick leave credits before temporary disability benefits are allowed will result in a situation wherein such usage of accumulated sick leave credits will extend beyond the duration of the waiting period as in the case of a full-time employee who has more than five days of accumulated sick leave credits at the onset of disability.)

(2) An employee may request the use of accumulated vacation leave credits during the working days of the waiting period after first exhausting his/her accumulated sick leave credits.

Example: At the onset of disability, an employee has two days of accumulated sick leave credits. Such employee must use the two days accumulated sick leave credits on the first two working days of the waiting period and may request that the remaining three working days of the waiting period be charged against his/her accumulated vacation leave credits.

I. BENEFIT YEAR

For purposes of this Plan, a "benefit year" shall be the calendar year, beginning on the first day of January and ending on the thirty-first day of December.

For an eligible employee hired after the first day of January, the "benefit year" shall begin on the date of hire and end on the thirty-first day of December of that year. The employee's subsequent "benefit year" shall begin and end as described above.

J. EMPLOYMENT STATUS DURING PERIOD OF DISABILITY

Waiting Period (seven calendar days)

(1) Sick Leave - Employee shall first use all accumulated sick leave credits on the working days of the waiting period.

(2) Vacation Leave - Employee, after using all accumulated sick leave credits, may request the use of accumulated vacation leave credits, including compensatory time credits, on the working days of the waiting period.

(3) Leave Without Pay - The working days during the waiting period which are not charged against the employee's accumulated sick leave or vacation leave credits shall be deemed as leave without pay.

Period of Disability During Which Employee Receives or Will Receive Temporary Disability Benefits

(1) Sick Leave - Employee shall first use all accumulated sick leave credits before temporary disability benefits are allowed.

(2) Leave Without Pay - Employee, after using all accumulated sick leave credits, shall be deemed to be on leave without pay.

(2) Employee shall not be permitted to use vacation leave and compensatory time credits during the period of disability in which temporary disability benefits are applicable.

Period of Disability During Which Temporary Disability Benefits Are Not Applicable

Vacation Leave and/or Leave Without Pay - Employee shall be allowed to request the use of accumulated vacation leave credits, including compensatory time credits, on the working days of the period of disability during which temporary disability benefits are not applicable. If such a request is not made or if made but not approved, the employee shall be deemed to be on leave without pay.

An employee shall not earn and accrue sick leave and vacation leave credits while on leave-without-pay status.

An illustration of an employee's employment status during the various phases of disability is shown on the following page.

Illustration of Employment Status During Period of Disability

Onset of Disability

End of Disability

WAITING PERIOD (7 calendar days)	PERIOD IN WHICH TDB ARE APPLICABLE	PERIOD IN WHICH TDB ARE NOT APPLICABLE
a. Sick Leave Must be used first. b. Vacation Leave & Compensatory Time Off Employee's option to request. c. Leave Without Pay If working days not charged to sick leave, vacation and/or CTO.	a. Sick Leave Must be used first. b. Leave Without pay After use of sick leave. c. Vacation Leave & Compensatory Time Off Not permitted.	a. Vacation Leave & Compensatory Time Off Employe's option to Request. b. Leave Without Pay If vacation leave and/or CTO is not requested or not approved.

TDB = Temporary Disability Benefits

K. PROCEDURE FOR DETERMINING SICK LEAVE COMPUTATION, DURATION OF TEMPORARY DISABILITY BENEFITS, AND AMOUNT OF WEEKLY TEMPORARY DISABILITY BENEFIT PAYMENT

Sick Leave Computation (SLC)

"Sick Leave Computation" means an employee's combined total of:

(1) Sick leave hours used from the first day of the current calendar year to the day preceding the current disability: _____hours

PLUS

(2) Sick leave hours earned but not used as of the first day of the current disability: _____hours

EQUALS

(3) SLC (in hours): _____hours

Duration of Temporary (TD) Benefits

The duration of TD benefits in weeks is shown on Tables A through A-10 and B. Such tables are based on the number of hours normally worked by an employee as follows:

Table	For Employees Who Normally Work:
A	More than 38 and up to 40 hours per week
A-1	" " 36 " " " 38 " " "
A-2	" " 34 " " " 36 " " "
A-3	" " 32 " " " 34 " " "
A-4	" " 30 " " " 32 " " "
A-5	" " 28 " " " 30 " " "
A-6	" " 26 " " " 28 " " "
A-7	" " 24 " " " 26 " " "
A-8	" " 22 " " " 24 " " "
A-9	" " 20 " " " 22 " " "
A-10	" " 18 " " " 20 " " "
B	56 hours per week (BU 11 employees)

(1) First Claim in Calendar Year

After calculating the employee's SLC pursuant to the first paragraph of this section, refer to the applicable table (Table A through A-10 or B) to determine the duration of the employee's entitlement to TD benefits as follows:

(a) Under the column entitled Sick Leave Computation in the applicable table, locate the number of SLC in hours and read across to determine the maximum duration of TD benefits allowed.

Example: Table A shows that if an employee's SLC is 80 to 119.9 hours, the maximum duration for receipt of TD benefits would be 5 weeks.

(b) It should be noted that if an employee's SLC provides sick leave coverage for a total of three weeks or more, the employee is not entitled to TD benefits for the calendar year and no further computation is required. However, the employee should be notified that his/her claim is being denied in accordance with the procedure on "Denial of Claim" found in Section M of this Plan.

(2) Other Than First Claim in Calendar Year

(a) At the onset of the current disability (second, third, etc. in the current calendar year), calculate the employee's SLC pursuant to the first paragraph of this section.

(b) If the employee's SLC provides sick leave coverage for a total of three weeks or more, the employee is not entitled to further TD benefits in the calendar year. However, if the employee's SLC provides sick leave coverage for less than three weeks, refer to the applicable table to determine the duration of the TD benefits for the current disability.

(c) Review the employee's previous TD benefit claim(s) to determine the duration of TD benefits actually used or received for previous disabilities in the current calendar year.

(d) Subtract the duration of TD benefits actually used or received for the employee's previous claim(s) in the current calendar year from the duration of TD benefits for the current claim as shown below:

(i) Duration of TD benefits for current claim: _____

MINUS

(ii) Duration of TD benefits actually used or received for previous claim(s) in the same calendar year: _____

EQUALS

(iii) Net duration of TD benefits for current claim: _____

Amount of Weekly Temporary Disability Benefit Payment

An employee's average weekly wage (AWW) must be determined before the "amount of weekly temporary disability benefit payment" can be established. The AWW is dependent upon the employee's gross wages which include wages and other forms of remuneration such as overtime, night differential, cash value of meals and lodging, etc. As such, the AWW for salaried and hourly paid employees shall be computed as follows:

(1) Salaried Employee With No Other Form of Remuneration

Multiply the employee's monthly salary for the month in which the disability commences by 12 and divide the product by 52 as follows:

$$\text{AWW} = \frac{\text{monthly salary x 12 months}}{\text{52 weeks}}$$

(2) Hourly Paid or Salaried Employee With Other Forms of Remuneration

Divide the employee's gross wages (salary/hourly sages plus other forms of remuneration) for the eight weeks or portion thereof immediately preceding and including the last day worked prior to the date disability began, by the number of weeks or portion thereof of the employment as follows:

$$\text{AWW} = \frac{\text{8 weeks gross pay (or portion thereof)}}{\text{8 weeks (or portion thereof)}}$$

After the AWW is determined, the "amount of the weekly temporary disability benefit payment" can be established.

The "amount of the weekly temporary disability benefit payment" is based on:

(1) 58% of the employee's average weekly wages (AWW) or

(2) the "maximum weekly benefit amount" (MWBA) as annually established by the Disability Compensation Division of the State Department of Labor and Industrial Relations,

whichever is less.

To illustrate:

(a)	58% of the employee's AWW ($255) is: (.58 x $255 = $147.90), rounded off to the next higher multiple of $1.00	$148.00
(b)	The 2000 MWBA set by the Labor Dept. is:	$372.00
	The amount of the weekly TD benefit is the lesser of (a) or (b) above:	**$148.00**

Partial Benefits

An employee who suffers a relapse after returning to work for less than full day shall:

(1) be paid partial benefits or

(2) be given waiting period credit for such day,

provided that, his/her wages for the partial day's work did not equal or exceed the prorated disability benefits to which he/she is entitled. The benefit amount is derived by subtracting the gross wages received for performing less than a full day's work from the prorated disability benefits to which he/she is entitled. (The prorated benefits are not rounded off to the next higher multiple of $1.00.)

Examples

(1) First Claim in Calendar Year

A full-time employee (40 hours per week) whose average weekly wage is $255 has used 40 hours of sick leave in the current calendar year and has 40 hours of sick leave credits earned but not used at the onset of disability. Should the employee meet the eligibility and other requirements, the TD benefits would be calculated as follows:

(a) Sick Leave Computation

40 hrs. of sick leave used
+ 40 hrs. of unused sick leave

SLC = **80 hours**

(b) Duration of TD Benefits:

Per Table A, if the employee's SLC is 80 hours, the duration of TD benefits would be 5 weeks.

(c) Weekly Amount of TD Benefit Payment:

(i) 58% of AWW = .58 x $255 = $147.90. The product of (.58 x AWW), if not a multiple of $1.00, is rounded off to the next higher multiple of $1.00 $148.00

(ii) MWBA (Y2000) = $372.00

Weekly amount of TD benefit is the lesser of (i) or (ii) above: = **$148.00**

In the above example, the employee would be entitled to 5 weeks of benefits at $148.00 per week and the maximum amount of benefits payable would be (4 x $148.00) $592.00. It should be noted that the employee, as in all cases, must serve a waiting period of 7 calendar days and must exhaust all unused sick leave credits prior to receiving benefits.

(2) Other Than First Claim in Calendar Year

A full-time employee (40 hours per week) whose average weekly wage is $255 has used 80 hours of sick leave in the current calendar year and has a zero balance of sick leave credits earned but not used at the onset of the second disability in the same calendar year. The employee received 2 weeks of TD benefits for the first disability in the calendar year. Should the employee meet the eligibility and other requirements, the TD benefits for the current or second disability in the calendar year would be calculated as follows:

(a) Sick Leave Computation:

80 hrs. of sick leave used
+ 0 hrs. of unused sick leave

SLC = 80 hours

(b) Duration of TD Benefits:

Per Table A, if the employee's SLC is 80 hours, the duration of TD benefits would be 5 weeks. However, since the employee received 2 weeks of TD benefits for a previous disability in the same calendar year, the employee is entitled to only 3 weeks of benefits for the second disability.

(i) Duration of TD benefits for current claim: 5 weeks

MINUS

(ii) Duration of TD benefits actually used or received for previous claims in calendar year: 2 weeks

EQUALS

(iii) Net duration of TD benefits current claim: **3 weeks**

(c) Weekly Amount of TD Benefit Payment

(i) 58% of AWW = .58 x $255 = $148.00

(ii) MWBA (Y2000) = $372.00

Weekly amount of TD benefit is the lesser of (i) or (ii) above: = **$148.00**

In the foregoing example, the employee would be entitled to 2 weeks of benefits at $148.00 per week for the second disability in the same calendar year and the maximum amount of benefits payable would be (2 x $148.00) $296.00. It should be noted that the employee, as in all cases, must serve a waiting period of 7 calendar days prior to receiving benefits.

L. FILING OF CLAIM FOR TEMPORARY DISABILITY BENEFITS

A claim for temporary disability benefits shall be filed on a form entitled "Claims for Temporary Disability Benefits" and designated as HRD (TDI)-1, Rev. 2/00. All departments shall be responsible for maintaining an adequate supply of such form for internal distribution.

A claim must be filed within ninety (90) days from the date of disability. Any claim filed after ninety (90) days from the date of disability shall be denied. (For employees entitled to earn and accrue sick leave, the 90-day period begins the date the employee exhausts sick leave.)

Alternate Form: In the event the above referenced claim form is not available, claims may be filed on form TDI-45 (Rev. 01/00), "Claims for Disability Benefits" issued by the Department of Labor and Industrial Relations.

M. DENIAL OF CLAIM

The following procedure shall be followed by all State agencies in denying an employee's claim for temporary disability benefits:

(1) Complete, in duplicate, the form entitled "Denial of Claim for Disability Benefits" (TDI-46, Rev. 01/00).

(2) Send a copy of the denial form, with the employee's completed claim form attached, to the Disability Compensation Division of the State Department of Labor and Industrial Relations for review. (AT THIS TIME, DO NOT SEND A COPY OF THE DENIAL FORM TO THE EMPLOYEE.)

(3) Follow Step A or B below:

Step A: If the review by the Disability Compensation (DC) Division results in a finding that the denial was:

(a) in error,

(b) without proper legal basis, or

(c) without sufficient supporting evidence,

then DC Division will contact the agency within ten (10) calendar days and make a request that the agency reconsider the denial determination. The reconsideration may be requested on "Review of Denial of Claim" (Form DC-46(a)). At such time, the agency may exercise one of the two following options:

(i) The agency may reconsider the denial and allow benefits. (The DC Division must be notified of such action in writing.)

(ii) The agency may disagree with the DC Division's request to reconsider the denial. In such event, the agency must send the employee three (3) copies of the denial notice and inform the DC Division of its action in writing. The agency must then complete the bottom portion of the Form DC-46(a) and return it to the DC Division within five (5) days.

Step B: If the agency does not receive a request for reconsideration from the DC Division within ten (10) calendar days, the agency may assume that the denial determination is proper. The agency should immediately send three (3) copies of the denial notice to the employee.

The agency may on its own discretion or initiative reconsider an adverse determination if subsequent information or new facts indicate that a reconsideration is in order. In such event, the employee and the DC Division must be notified in writing immediately so that a hearing will not be scheduled.

N. APPEAL PROCEDURE

If a claim for temporary disability benefits is denied, the employee may appeal the decision of denial to the Disability Compensation Division of the State Department of Labor and Industrial Relations. The appeal must be filed:

(1) within twenty (20) days from the mailing date of the notice of denial or

(2) if not mailed, within twenty (20) days from the date the notice of denial was forwarded to the employee.

The claimant's appeal form is contained on the reverse side or second page of the Denial of Claim for Disability Benefits form (TDI-46, Rev. 01/00).

TABLE A

DURATION OF TEMPORARY DISABILITY (TD) BENEFITS

(for employees who normally work
more than 38 and up to 40 hours per week)

*SICK LEAVE COMPUTATION (SLC) (in hours)	DURATION OF TD BENEFITS (in weeks)
Please see following page for update to Table A - A10	

DURATION OF TD BENEFITS AFTER FIRST CLAIM IN CALENDAR YEAR

The duration of TD benefits for other than the first claim in a calendar year shall be computed as follows:

(a) Duration of TD benefits for current claim: _____

MINUS

(b) Duration of TD benefits actually used for previous claim(s) in the same calendar year: _____

EQUALS

(c) Net duration of TD benefits for current claim: _____

*Sick Leave Computation (SLC) is an employee's combined total of
(a) sick leave hours used from the first day of the current calendar year to the day preceding the current disability and
(b) sick leave hours earned but not used as of the first day of current disability.

**SLC provides sick leave coverage for a total of three weeks or more.

Note: Section H of the TD Benefits Plan requires that an employee shall serve a mandatory waiting period of seven consecutive calendar days starting from the first day of each disability before temporary disability benefits become applicable.

DURATION OF TEMPORARY DISABILITY (TD) BENEFITS FOR BARGAINING UNIT AND NON-BARGAINING UNIT EMPLOYEES

First find the applicable table based on the number of hours that the employee normally works per week. Then under applicable table, find the TD benefits allowable based on the employee's sick leave computation (SLC) in hours.

	Table A for employees who work more than 38 and up to 40 hours per week	Table A-1 for employees who work more than 36 and up to 38 hours per week	Table A-2 for employees who work more than 34 and up to 36 hours per week	Table A-3 for employees who work more than 32 and up to 34 hours per week	Table A-4 for employees who work more than 30 and up to 32 hours per week	Table A-5 for employees who work more than 28 and up to 30 hours per week
DURATION OF TD BENEFITS	SICK LEAVE COMPUTATION (SLC) in hours					
None***	120 or more	114 or more	108 or more	102 or more	96 or more	90 or more
5 weeks (25 days)	80 to 119.9	76 to 113.9	72 to 107.9	68 to 101.9	64 to 95.9	60 to 89.9
6 weeks (30 days)	40 to 79.9	38 to 75.9	36 to 71.9	34 to 67.9	32 to 63.9	30 to 59.9
26 weeks (130 days)	39.9 or less	37.9 or less	35.9 or less	33.9 or less	31.9 or less	29.9 or less

	Table A-6 for employees who work more than 26 and up to 28 hours per week	Table A-7 for employees who work more than 24 and up to 26 hours per week	Table A-8 for employees who work more than 22 and up to 24 hours per week	Table A-9 for employees who work more than 20 and up to 22 hours per week	Table A-10 for employees who work more than 18 and up to 20 hours per week
DURATION OF TD BENEFITS	SICK LEAVE COMPUTATION In hours				
None***	84 or more	78 or more	72 or more	66 or more	60 or more
5 weeks (25 days)	56 to 83.9	52 to 77.9	48 to 71.9	44 to 65.9	40 to 59.9
6 weeks (30 days)	28 to 55.9	26 to 51.9	24 to 47.9	22 to 43.9	20 to 39.9
26 weeks (130 days)	27.9 or less	25.9 or less	23.9 or less	21.9 or less	19.9 or less

****SLC includes sick leave coverage for a total of three weeks or more.*

DURATION OF TEMPORARY DISABILITY (TD) BENEFITS FOR NON-BARGAINING UNIT EMPLOYEES (less than 20 hours of work per week)

	Table A-11 for employees who work more than 16 and up to 18 hours per week	Table A-12 for employees who work more than 14 and up to 16 hours per week	Table A-13 for employees who work more than 12 and up to 14 hours per week	Table A-14 for employees who work more than 10 and up to 12 hours per week	Table A-15 for employees who work no more than 10 hours per week
DURATION OF TD BENEFITS	SICK LEAVE COMPUTATION In hours				
None***	54 or more	48 or more	42 or more	36 or more	30 or more
5 weeks (25 days)	36 to 53.9	32 to 47.9	28 to 41.9	24 to 35.9	20 to 29.9
6 weeks (30 days)	18 to 35.9	16 to 31.9	14 to 27.9	12 to 23.9	10 to 19.9
26 weeks (130 days)	17.9 or less	15.9 or less	13.9 or less	11.9 or less	9.9 or less

****SLC includes sick leave coverage for a total of three weeks or more.*

TABLE B

DURATION OF TEMPORARY DISABILITY (TD) BENEFITS FOR BU 11 EMPLOYEES ON 56-HOUR WORKWEEK

Notwithstanding any provision contained in the Temporary Disability Benefits Plan to the contrary, the duration of TD benefits for BU 11 employees who work an average of 56 hours per workweek based on 24-hour work shifts shall be determined in the manner provided herein.

A. NO TD BENEFITS

1. If an employee, on the first day of a benefit year (January 1st) or at the time of disability, has a sick leave balance which will provide at least 192 hours or 8 work shifts of sick leave coverage, the employee shall not be entitled to TD benefits in that benefit year.

2. If an employee, at the time of disability, has a combined total of used and unused sick leave credits (hereafter referred to as sick leave computation or SLC) which has provided or will provide at least twenty-one days of sick leave coverage, the employee shall not be entitled to TD benefits in the benefit year.

B. PROCEDURE FOR DETERMINING DURATION OF TD BENEFITS

1. The duration of TD benefits for a disabled employee's first claim in a calendar year shall be determined as follows:

   a. Refer to Section C of this Table and compute the employee's "Sick Leave Computation" (SLC) in shifts.

      SLC in shifts: _____

   b. Review the employee's work schedule starting from the employee's first workday of disability and count the number of shifts that the employee is scheduled to work during the:

      (1) First 7 calendar days: _____ shifts

      (2) 8th through 14th day: _____ shifts

      (3) 15th through 21st day: _____ shifts

   c. Refer to Section D of this Table and determine which "work shift combination" (A, B, C, D, E, F or G) coincides with the employee's work schedule.

      Work Shift Combination: _____

d. Refer to Section E of this Table to find the duration of TD benefits as follows:

Locate the employee's SLC in shifts and move horizontally across the Table until you reach the column for the employee's "work shift combination." At this point, the maximum duration of TD benefits for the employee is shown in weeks.

Maximum Duration of TD Benefits: _____ weeks

2. The duration of TD benefits for other than the first claim in a calendar year shall be computed as follows:

a. Duration of TD benefits for current claim: _____
(repeat procedure 1a to 1d above)

MINUS

b. Duration of TD benefits actually used for previous claim(s) in same calendar year: _____

EQUALS

c. Net duration of TD benefits for current claim: _____

C. SICK LEAVE COMPUTATION (SLC)

"Sick Leave Computation" means an employee's combined total of:

(1) Sick leave hours used from the first day of the current calendar year to the day preceding the current disability: _____hours

PLUS

(2) Sick leave hours earned but not used as of the first day of the current disability: _____hours

EQUALS

(3) SLC (in hours): _____hours

(4) Convert the SLC hours to 24-hour work shifts as follows:

$$\frac{\text{SLC hours}}{24} =$$ **SLC** _____**shifts**

(Note: For SLC purposes, drop any fraction of a shift.)

D. WORK SHIFT COMBINATIONS

The different work shift combinations which a disabled employee may be scheduled for during any 21-day period (based on 7-day increments) starting from the first work day of disability are as follows:

	WORK SHIFT COMBINATIONS						
	A	B	C	D	E	F	G
First 7 calendar days: (1st 7-day increment)	2	2	2	2	3	3	3
8th through 14th day: (2nd 7-day increment)	2	2	3	3	2	2	3
15th through 21st day: (3rd 7-day increment)	2	3	2	3	2	3	2

E. DURATION OF TD BENEFITS TABLE

WORK SHIFT COMBINATIONS

SLC (in shifts)	A (2-2-2)	B (2-2-3)	C (2-3-2)	D (2-3-3)	E (3-2-2)	F (3-2-3)	G (3-3-2)
	DURATION OF TD BENEFITS (in weeks)*						
0	26	26	26	26	26	26	26
1	26	26	26	26	26	26	26
2	5	5	5	5	26	26	26
3	4 1/2	4 1/2	4 2/3	4 2/3	5	5	5
4	4	4	4 1/3	4 1/3	4 1/2	4 1/2	4 2/3
5	3 1/2	3 2/3	4	4	4	4	4 1/3
6	0	3 1/3	3 1/2	3 2/3	3 1/2	3 2/3	4
7	0	0	0	3 1/3	0	3 1/3	3 1/2
8	0	0	0	0	0	0	0

*Before TD benefits become payable, an employee shall be required to:

(1) serve a 7-day waiting period starting from the first day of each disability and
(2) exhaust all unused sick leave credits.

Department's Mailing Address:

Department: _____
Attn: _____
Address: _____
_____

HRD(TDI)-1
Rev. 2/00

CLAIM FOR TEMPORARY DISABILITY BENEFITS

INSTRUCTIONS: To avoid unnecessary delay, present your claim form to your department under Step 3, below, no later than 90 days after you are unable to perform the duties of your job. If you file beyond 90 days, attach a statement explaining why you were unable to file earlier. After you file your claim, a departmental representative will notify you if you are eligible for benefits. Follow the 3 steps below:

Step 1. Answer all questions in Part A, Claimant's Statement. Make sure you sign your name, or if you are unable to, have a responsible person sign for you.

Step 2. Have your doctor complete and sign Part B, Doctor's Statement.

Step 3. Have your doctor mail this form to your department (see top portion of this page for your department's mailing address).

PART A – CLAIMANT'S STATEMENT

1. My name is: (First, middle, last) Type or print	2. Social Security Number
3. Address (Street, City or Town, State, Zip Code)	4. Telephone Number

DISABILITY INFORMATION

5. My disability was caused by: ☐ sickness, ☐ accident. Describe (if accident, give date, place and circumstances): _____	
6. The first day I was unable to perform the duties of my job: _____ (month) (day) (year)	7. Was this disability caused by your job? ☐ Yes, ☐ No, ☐ Unknown
8. I ☐ have not ☐ have recovered from my disability. Date recovered: _____	9. I ☐ have not ☐ have returned to work. Date returned to work: _____

EMPLOYMENT INFORMATION

10. Department: Division:	11. Work Address: _____ (Street) (City) (State) (Zip)
12. Prior to my disability, I worked for this employer From _____ (Mo.) (Day) (Yr.) to _____ (Mo.) (Day) (Yr.)	13. I worked: _____ Hrs. per week / 14. I earned: $ _____ per week
15. Occupation:	16. Bargaining Unit: ☐ BU _____ or ☐ Excluded

17. Other Hawaii employers I worked for during the past 52 weeks.

Employer Name and Address	Period of Employment: From Mo.	From Day	From Yr.	To Mo.	To Day	To Yr.	Weekly: Hours	Weekly: Wages
a.								
b.								
c.								
d.								

PART A – CLAIMANT'S STATEMENT (CONTINUED)

OTHER BENEFITS

18. In addition to TDI benefits, I am receiving or claiming benefits from the following:

☐ Fed. Disability Ins. Benefits ☐ Unemployment Ins. Benefits ☐ Damages for Personal Injury

☐ Workers' Comp. Benefits ☐ State Sick Leave Plan ☐ Accidental Inj. Lv. (Act 64)

☐ Other (Health & Welfare Fund, Union Plan, etc.)

19. During the current calendar year, I have received TDI benefits for other periods of disability.

☐ Yes, ☐ No If yes, from whom _____ From _____ to _____

I hereby claim Temporary Disability Benefits and certify that the foregoing statements including any accompanying statements are true and complete to the best of my knowledge.

Claimant's signature:	Date:
Representative's signature, if claimant unable to sign	Print Representative's Name & Relationship

PART B – DOCTOR'S STATEMENT

IMPORTANT: **Please complete and mail within 7 working days after examination to the employee's department (see top portion of first page for department's mailing address).**

1. Claimant's Name: _____

2. Physical requirements of claimant's occupation as related by claimant: _____

3. Diagnosis:

4. If pregnancy advise EDC _____. If disability is pregnancy with complications, advise in item #3 above.

5. Was claimant's disability caused by his/her employment: ☐ Yes ☐ No

If yes, was Physician's Report WC-2 filed? ☐ Yes ☐ No If yes, filed with _____

6. Was claimant hospitalized? ☐ Yes ☐ No If yes, from _____ to _____

Surgery indicated? ☐ Yes ☐ No Type: _____

7. Complete the following:	Mo.	Day	Yr.
a. Date of your first treatment of this disability			
b. First date claimant unable to perform the duties of employment (see 2 above)			
c. Date of your most recent treatment of this disability			
d. Estimated date claimant will be able to perform usual work (see 2 above)			

8. Are you referring claimant to another physician ☐ or was claimant referred to you ☐?

Give name of physician: _____

I hereby certify that the above information is true and complete to the best of my knowledge.

Print Dr.'s name: _____ Office Add.: _____

Doctor's signature: _____ Tel. No. _____ Date: _____

PART C – DEPARTMENT'S STATEMENT

IMPORTANT: Part C must be completed in its entirety.

1. Claimant worked:
   ☐ Full-time; ☐ Part-time

2. Date hired:
   (Mo/Day/Yr) _____ / _____ / _____

3. Date last worked prior to disability:
   (Mo/Day/Yr) _____ / _____ / _____

4. If returned to work, give date:
   (Mo/Day/Yr)_____ / _____ / _____

5. Circle days normally worked: Su M T W Th F Sa
   If on rotation, give number of days worked per week: _____ days/week.

6. Do you think disability was caused by claimant's job?
   ☐ Yes, ☐ No, ☐ Unknown

7. Was an Employer's Report of Industrial Injury WC-1 filed?
   ☐ Yes, ☐ No

8. Has or will this employee receive wages, salary, sick leave, or vacation pay for all or any part of the period of disability covered by this claim?
   ☐ No, ☐ Yes from _____ (Month/Day/Year) through _____ (Month/Day/Year). Amount: _____

9. Enter the following for the past 52 weeks prior to date disability began:

Calendar Quarter Ending	Number of Weeks Worked	No. of Hours Worked per Wk.	Total Wages Earned

10. In reporting wage information below, use gross wages which include wages and all other remuneration such as cash value of meals, lodging, etc. (Answer either A or B.) If claimant was paid:

    A. On a salary basis and received no other form of remuneration, enter monthly salary amount for month disability began: $ _____.

    B. On an hourly or salary basis and received other forms of remuneration give rate per hour: $ _____.
    Enter weekly earnings for the past 8 weeks prior to date disability began, including last date worked.

Week No.	Week Ending Month	Day	Year	No. Days Worked	Gross Amount
1					
2					
3					
4					
5					
6					
7					
8					
TOTAL	XXXX	XXXX	XXXX		

Complete for A and B
Weekly Benefit Amount $ _____
No. of Weeks Eligible _____

☐ Meets requirements; approved.

☐ Disapproved; Reason: _____

_____

_____
Signature of Department Head/Designee

_____
Title Date

Form TDI-46
(Rev. 1/2000)

DENIAL OF CLAIM FOR DISABILITY BENEFITS

(This form is prescribed for use by employers and insurance carriers for the denial of a claim for disability benefits. This notice is to be mailed to the claimant in triplicate to give the claimant the opportunity of filing an appeal with the Department of Labor and Industrial Relations.)

Claimant's Name and Address		Employer's Name and Address	
Social Security Number		Department of Labor Account Number	
First Date of Disability Claimed		Insurance Carrier's Name and Address	
Date Claim Filed	Date Notice Sent To Dept.: _____ To Claimant: _____		
Claim or File No.		Telephone No.	FAX No.

You are hereby notified that your claim for Disability Benefits is denied under the provisions of the Hawaii Temporary Disability Insurance Law for reason(s) checked below. (Check each item on which claim is being denied.)

- ☐ 1. You do not meet the eligibility requirements. You must work at least 20 hours each week for 14 weeks during the 52 weeks immediately preceding the first day of disability; and have earnings of at least $400. Employment must have been with covered Hawaii employers.
- ☐ 2. You were not in current employment; i.e., you did not perform regular service in covered Hawaii employment immediately or not longer than two weeks prior to the onset of the sickness or accident causing disability, or prior to becoming totally disabled because of pregnancy.
- ☐ 3. You were not disabled beyond the 7 consecutive-day waiting period. (Statutory benefits commence on the 8th day of disability.)
- ☐ 4. You have received 26 weeks of benefits, the maximum payable during a benefit year.
- ☐ 5. Your claim was filed on _____ . A claim must be filed within **90 days after** commencement of disability or as soon thereafter as is reasonably possible. Benefits need not be paid for any period more than 14 days prior to the date the required proof is furnished, unless good cause can be shown for the late filing. No benefits shall be paid unless proof of disability is furnished within 26 weeks after commencement of disability.
  - ☐ No benefits are payable.
  - ☐ Payments will commence 14 days prior to date claim was filed.
- ☐ 6. You have indicated that you are claiming benefits under the Workers' Compensation Law of this State or any other state.
- ☐ 7. Medical records indicate you were able to perform regular work on _____
  Payment of benefits is denied after _____
- ☐ 8. The medical certification does not establish that you were unable to perform your regular work due to a disability.
- ☐ 9. You were not under the care of a physician, dentist, chiropractor, osteopath, naturopath, or equivalent during the period _____ to _____
  - ☐ No benefits are payable.
  - ☐ Payments will commence _____
- ☐ 10. You are entitled to benefits under your union contract.
- ☐ 11. We are not the insurance carrier for the employer listed above.
  - ☐ Your claim has been forwarded to _____
  - ☐ Your claim is returned. For correct insurance carrier, call TDI office, 586-9188.
- ☐ 12. Other reasons for denial: _____

Authorized Signature	Title

TO CLAIMANT: If you do not agree with this denial of your claim, you must file an appeal within 20 days from the date of receipt of this notice by you. Use reverse side of this form to file your appeal.

INSTRUCTIONS TO CLAIMANT

1. Give specific reasons for appealing for each item of denial checked on the face of this form.
2. Attach any medical evidence and/or employment records that will support your appeal.
3. Complete all copies of this form received from your employer or insurance company.
4. Mail two copies promptly to: **Department of Labor and Industrial Relations**
   Disability Compensation Division
   P.O. Box 3769
   Honolulu, Hawaii 96812-3769
5. Retain one copy for your record.
6. File the Claimant's Appeal within 20 days after the date of the receipt of this notice.

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment.

CLAIMANT'S APPEAL

My claim for Disability Benefits has been denied and I hereby appeal such denial, for the following reason(s): (Answer only with respect to items of denial checked on face of this form.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date Notice of Denial of Claim for Disability Benefits received by Claimant: _____

Claimant's Signature _____ Date: _____

Notice to Employees Included in Collective Bargaining
Units 1, 2, 3, 4, 9, 10, 11, and 13

TEMPORARY DISABILITY BENEFITS PLAN

The Department of Labor and Industrial Relations has approved the State's Temporary Disability Benefits Plan for employees included in collective bargaining units 1, 2, 3, 4, 9, 10, 11, and 13.

The Plan is intended to provide temporary disability benefits to employees who are unable to work because of non-work related injury or illness and who do not have sick leave coverage for a total of three weeks or more at the time of disability or at the beginning of the calendar year.

- An employee who has a combined total of used and unused sick leave equaling at least three weeks or 120 hours prior to his/her first day of disability or at the beginning of the calendar year is not entitled to TDI benefits.
- A BU 11 employee who has a combined total of used and unused sick leave equaling at least 192 hours or 8 work shifts prior to his/her first day of disability or at the beginning of the calendar year is not entitled to TDI benefits.

The specific temporary disability benefit provides partial wage replacement up to a maximum duration of 26 weeks per benefit year after:

(1) serving a mandatory seven calendar day waiting period starting from the first day of each disability and
(2) using all accumulated (unused) sick leave credits before the benefit is allowed.

The amount of the temporary disability benefit is based on:

(1) 58% of the employee's average weekly wages or
(2) the "maximum weekly benefit amount" as annually established by the Disability Compensation Division of the State Department of Labor and Industrial Relations,

whichever is less.

To be eligible for benefits, an employee during any part of the 52 weeks immediately prior to the first day of the disability must have:

(1) worked for any covered employer in the State of Hawaii for at least 14 calendar weeks,
(2) received remuneration in any form for twenty or more hours during each of the 14 weeks, and
(3) earned at least $400.

(The Plan contains other conditions and requirements which must be met before benefits are allowed.)

If an employee is unable to work because of a non-work related injury or illness and feels that he/she may be eligible for benefits under the Plan, he/she must file a claim within 90 days from the date of disability.

Claim forms are available at: _____.
A copy of the State's Temporary Disability Benefit Plan is also available for review at the same location.

If you have any questions regarding the Plan, please contact: _____.

Appeal Rights:An employee who disagrees with any decision rendered on his/her claim may file an appeal with the Disability Compensation Division of the State Department of Labor and Industrial Relations within twenty (20) days from the mailing date of the Notice of Denial.